



## Five Year Forward View Plan

Cross-Cutting Theme/LDS Programme:

Demand Management and Prevention at scale

Service/Theme: Alcohol Harm Reduction

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## Contents

Template – Rationale and Notes for Use

Executive Summary

1. National, Regional, Local Context

2. Assumptions & Constraints

3. Model of Care and/or Service Model

4. Performance

5. Staffing

6. Information Management & Technology

7. Facilities & Estate

8. Interdependencies

9. Benefits

10. Proposed Action Plan(s)

a) Annexes

1. Appendices

## Template – Rationale and Notes for Use

### Rationale

The Five Year Forward View (5YFV) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

The FYFV Executive summary highlights the following:

- The NHS has dramatically improved over the past fifteen years.
- there is now quite broad consensus on what a better future should be
- radical upgrade in prevention and public health
- when people do need health services, patients will gain far greater control of their own care
- the NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'
- **Create integrated out-of-hospital care - the Multispecialty Community Provider**
- **Primary and Acute Care Systems**
- **Urgent and emergency care**
- **Smaller hospitals will have new options to help them remain viable**
- **Specialised Care**
- **Midwives will have new options to take charge of the maternity services they offer**
- **The NHS will provide more support for frail older people living in care homes**
- In order to support these changes, the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility
- We will improve the NHS' ability to undertake research and apply innovation
- it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local

The seven lines in **bold** are '**New Models of Care**' explained at pp. 20-26 of the 5YFV. Sustainability & Transformation Plans (FYFVs) are a delivery mechanism for the 5YFV, they are the practical expression of the belief that one of the most powerful ways to achieve change is by working together – across entire communities and pathways of care – to find ways to close the gaps between where we are now and where we need to be in 2020/21.

**In October 2016, FYFVs are required to submit more detailed plans to NHSE and the partner ALBs. Completion of these PIDs for our 3 LDSs and 7 Cross-Cutting Themes will allow us to present a consistent and coherent picture of these 10 suites of programmes at the heart of the C&M FYFV.**

### Use

All Cross-Cutting Theme Leads and LDS Programme Leads are requested to use this template both as a guide and the structure of the description of how the Vanguard/Programme/Initiative is configured, what it is aiming to achieve and the benefits that will accrue. **For all the sections within the template there are brief notes of guidance as to the suggested content for that section at the beginning. These are in italics and maybe left in the document, for the sake of clarity, or deleted when understood, according to the preference of the team compiling the report.**

The current owner of this template is the C&M FYFV Portfolio Management Office (PMO) and, therefore, all suggested amendments to the template should be passed to the PMO.

## Executive Summary

*The executive summary should contain only text and include no new material; it should contain only words already found elsewhere in the document. The executive summary should aim to convey all the key messages of the report on a page. It should enable the reader to understand the important points upon which to focus, at a glance.*

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### The challenge

Alcohol is a cause of a wide range of health and social harms for individuals, their families and communities across Cheshire and Merseyside. In addition alcohol-related harm currently places a significant financial burden upon local public services.

None of this harm is inevitable and much could be prevented by taking a system wide approach to reducing alcohol-related harm.

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

### The 'do-nothing' scenario

If we 'do nothing' the implications for population health outcomes and the financial health of our local services across Cheshire and Merseyside will be stark. Put simply 'doing nothing' is not an option.

- **Health and Wellbeing:** Drinking at levels that can harm health is currently common. In Cheshire and Merseyside, 26.5% of the adult population consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health. Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. In addition to its impacts upon health alcohol is associated with significant social harms such as violence, domestic abuse and road traffic accidents. We also know that it is the poorer members of our communities who suffer the highest levels of alcohol-related harm. If we do not act now to reduce alcohol-related harm then increases in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend on wholly avoidable illness.
- **The financial impact:** If we do nothing alcohol misuse across Cheshire and Merseyside will continue to cost around **£994 million each year** (£412 per head of population):
  - **£218 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£81 million in social services cost** (Children's and adults social service provision)
  - **£276 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, licensing enforcement costs).
  - **£430 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)

## Closing the Five Year Forward View ‘Gaps’ by reducing alcohol-related harm

Reducing alcohol-related harm will contribute towards the closing of all three ‘gaps’ highlighted in the Five Year Forward View.

### 1. Closing the Health and Wellbeing Gap

On an **operational level**, the programme of work aims to prevent, identify and manage alcohol-related harm. The impact of this will be a reduction in emergency admissions due to alcohol and alcohol-related conditions and reduced demand on health and social care.

On a **tactical level within the C&M FYFV**, upstream approaches to address alcohol-related harm will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, High Blood Pressure, mental health).

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to alcohol, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

### 2. Closing the Care and Quality Gap

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions. The proposed interventions to reduce alcohol-related harm will help close the care and quality gap. Closing this gap will lead to observed benefits in terms of fewer hospital admissions and saved bed days. Benefits will be realised over the five years, not only at the five year point.

By year 5, the following benefits will be obtained:

<b>Cheshire and Merseyside:</b>	4,081 fewer admissions due to alcohol Equating to 16,326 bed days saved
<b>Wirral and Cheshire LDS:</b>	1723 fewer admissions due to alcohol Equating to 6894 bed days saved
<b>Mid Mersey Alliance LDS:</b>	1088 fewer admissions due to alcohol Equating to 4,352 bed days saved
<b>North Mersey LDS:</b>	1270 fewer admissions due to alcohol Equating to 5080 bed days saved

### 3. Closing the Finance and Efficiency Gap

In order to deliver the programme of work, financial resource is needed over a five year period. This investment will lead to significant returns. At a Cheshire and Mersey level **an investment of £2,457,000 over 5 years** (Yr 1: £278,000, Yr 2: £441,000, Yr 3: £560,000, year 4: £564,000, Yr 5: £614,000) will **realise savings of £13,731,000** (Yr 1: £615,000, Yr 2: £2,103,000 Yr 3: £2,745,000, Yr 4: £3,627,000 Yr5: £4,641,000).

The **net financial benefit** at after 5 years of implementing the proposed interventions set out within this alcohol programme has been estimated at:

- **Cheshire and Merseyside:** £11,274,000
- **Cheshire and Wirral LDS:** £4,760,000
- **Mid Mersey Alliance LDS:** £3,005,000
- **North Mersey LDS:** £3,508,000

These are likely to be underestimations of the proposed financial benefits.

### **The Cheshire and Merseyside cross sector system approach to reducing alcohol-related harm**

There is enormous scope within Cheshire and Merseyside to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan.

### **Proposed Service Model: Priority interventions to reduce demand**

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

In order to reduce alcohol-related harm within Cheshire and Merseyside we propose the following:

- 1) Enhanced support for high impact drinkers in hospital and community settings
  - A. Develop **multi-agency approaches to support change resistant drinkers**
  - B. Ensure the **provision of best practice multidisciplinary alcohol care teams in all acute hospitals.**
  - C. Review alcohol treatment pathways and **commission outreach teams in hospitals or the community** that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.
- 2) Large scale delivery of targeted brief advice
  - A. Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and **provide brief advice** and refer to local specialist services as required.
  - B. Ensure screening and advice by non-NHS partners as part of the delivery of **Making Every Contact Count (MECC) interventions.** This will include evidence-

based alcohol IBA as well brief interventions focusing on High Blood pressure (BP) (including BP checks), smoking cessation, diet and physical activity.

- 3) Effective population-level actions are in place to reduce alcohol-related harms
  - A. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards (As outlined by College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence).
  - B. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
  - C. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made.

This will include:

    - i. Targeting interventions to prevent violence and reduce alcohol-related harm
    - ii. Targeting police enforcement in hotspot areas
    - iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm. This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

### **Key performance indicators**

It is proposed that progress be monitored by four key performance indicators:

- **KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE)**
- **KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)**
- **KPI3: - Identification and Brief Advice (IBA) (Local indicators need to be developed)**
  - A. Alcohol screening:** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
  - B. Alcohol brief advice:** Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice
  - C. Alcohol referral:** Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team
- **KPI4: Alcohol-related violence (Local indicator needs to be developed)**

## 1. National, Regional, Local Context

***This section should describe*** relevant national standards, trends and challenges related to the team/service line activity that is the subject of the document. In particular, NHSE or other Arm's Length Body (ALB) policy guidance, national frameworks and demographic trends are likely to be some of the key points of reference to consider when constructing your vision. However, the section must be concise and limit this description to those aspects that bear directly upon the context in this geographic location. ***This section should also exploit the NHSE 'FYFV footprint analyses pack for Cheshire and Merseyside' as well as the 'FYFV Aides Memoire'.***

***Moreover, this section should go on to describe*** relevant regional/local standards, trends and challenges related to the team/ service line activity that is the subject of the document; in particular, regional/local commissioning intention and contractual arrangements. The report should bring into focus any regional/local pilots or projects that have a bearing on the team/service. The key local stakeholders, who are influencing the current and future scope of team/service delivery, should be identified.

***Your Plan for the 'Cross-Cutting Theme' or 'LDS Programme'*** should then describe which policies and guidance you will use the change programme as an opportunity to further develop.

### The Case for Change

Alcohol is a cause of a wide range of health and social harms for individuals, their families and communities across Cheshire and Merseyside. In addition alcohol currently places a significant financial burden upon local public services.

None of this harm is inevitable and much could be prevented by taking a system wide approach to reducing alcohol-related harm.

This programme plan sets out actions which if delivered at scale will prevent alcohol-related harm, improve health and social outcomes for individuals and communities and reduce demand on local services across health, social services and criminal justice settings.

#### a) The National Context

- Alcohol related harm costs England around £21bn per year, with £3.5bn to the NHS, £11bn tackling alcohol-related crime and £7.3bn from lost work days and productivity costs
- Alcohol is 10% of the UK burden of disease and death, making alcohol one of the three biggest lifestyle risk factors for disease and death in the UK, after smoking and obesity.
- Drinking at levels that can harm health is common. In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression.



- In England in 2014/15 there were 1.1 million estimated admissions where an alcohol-related disease, injury or condition was the primary reason for admission or a secondary diagnosis. This is 3% more than 2013/14.
- In England in 2014, there were 6,831 deaths which were related to the consumption of alcohol. This is an increase of 4% on 2013 and an increase of 13% on 2004.
- In England and Wales, 63% of all alcohol-related deaths were caused by alcoholic liver disease. Liver disease is one of the few major causes of premature mortality that is increasing. Deaths from liver disease have reached record levels, rising by 20% in a decade.
- There were 8,270 casualties of drink driving accidents in the UK in 2013, including 240 fatalities and 1,100 people who suffered serious injury.
- Alcohol places a significant burden upon NHS, local government and emergency services:
  - In 2009/10 there were 1.4 million alcohol-related ambulance journeys, which representing 35% of the overall total.
  - Estimates for the proportion of Emergency Department attendances attributable to alcohol vary, but figures of up to 40% have been reported, and it could be as much as 70% at peak times.
  - Up to 80% of weekend arrests are alcohol-related, and just over half of violent crime is committed under the influence.
  - Alcohol misuse is consistently found in a high proportion of those who perpetrate domestic abuse and sexual assault. Research has shown that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault.
  - Alcohol is typically found to be involved in 10-30% of all fires. Moreover, alcohol-caused fires are usually worse: 50% result in casualties, compared to 14% for other fires.
  - A survey of front line emergency survey staff found that dealing with alcohol-related harm takes up as much as half of their time.
  - 24% of children's social work is related to alcohol misuse, between 15-45% of adult social work cases are alcohol-related.
  - 89,107 individuals were treated at a specialist alcohol misuse service in England in 2014/15.

## **b) Standards and Policy Context**

- Best practice for the prevention and clinical management of alcohol-related harm is set out within NICE guidelines and accompanying Quality Standards enable assessment of performance against the guidelines.
- International and National policy emphasises that alcohol harm is a major public health issue and outlines the need to take a truly cross sector approach in order to be successful in reducing alcohol-related harm:
  - WHO: Global strategy to reduce harmful use of alcohol
  - EU: The EU Alcohol strategy
  - HM Government: The Government Alcohol Strategy

- HM Government: The Modern Crime Prevention Strategy
- Health First: An evidence based alcohol Strategy for the UK

### c) The Challenge in Cheshire and Merseyside

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions.

When compared to England:

- Alcohol has a significant impact upon the Cheshire and Merseyside economy. The costs from alcohol-related harm are extensive and fall across many areas including health and social care, crime, licensing and the workforce. Alcohol misuse across Cheshire and Merseyside costs around **£994 million each year** (£412 per head of population). Of these costs:
  - **£218 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£81 million in social services cost** (Children's and adults social service provision)
  - **£276 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, licensing enforcement costs).
  - **£430 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In Cheshire and Merseyside, 26.5% of the adult population (623,477 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
  - 9 out of the 12 CCGs have significantly higher rates of alcohol specific admissions
  - 7 out of 12 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
  - 9 out of 12 CCGs have significantly higher rates of alcohol related admissions (broad definition).
  - 7 out of 12 CCGs have significantly higher rates of alcohol specific mortality
  - 7 out of 12 CCGs have significantly higher rates of Mortality from chronic liver disease
  - 9 out of 12 CCGs have significantly higher rates of hospital admission episodes for mental and behavioural disorders due to use of alcohol condition (Broad)
  - 6 out of 12 CCGs have significantly higher rates hospital admission episodes for alcoholic liver disease condition (Broad)

- In terms of numbers affected across Cheshire and Merseyside:
  - 1,212 people died from an alcohol-specific condition between 2012 and 2014.
  - 1,150 people died from chronic liver disease between 2012 and 2014.
  - 13,845 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 37,865 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

#### d) The Challenges at Local Delivery System Level

The following LDS-level figures are based on main constituent CCG boundaries rather than exact LDS boundaries so may be subject to minor changes, i.e. they are based on the following footprints:

- **Cheshire and Wirral LDS:** South Cheshire, Eastern Cheshire, West Cheshire , Wirral, Vale Royal CCGs
- **The Mid Mersey Alliance LDS:** Knowsley, Warrington, Halton, St Helens CCGs
- **North Mersey LDS:** Liverpool, Southport & Formby, South Sefton CCGs

*Please note: the real picture is more complex, with some CCGs, e.g. Knowsley CCG, facing into more than one LDS. More accurate LDS-level figures will be calculated as part of the next stage in the FYFV process.*

#### i. Cheshire and Wirral LDS

- Alcohol misuse across the Cheshire and Wirral LDS costs around **£397 million** each year. Of these costs:
  - **£86 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£32 million in social services cost** (Children's and adults social service provision)
  - **£100 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
  - **£185 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the Cheshire and Wirral LDS, 27% of the adult population (270,045 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
  - 2 out of the 5 CCGs have significantly higher rates of alcohol specific admissions
  - 1 out of 5 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and

- 2 out of 5 CCGs have significantly higher rates of alcohol related admissions (broad definition).
- 1 out of 5 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the Cheshire and Wirral LDS:
  - 440 people died from an alcohol-specific condition between 2012 and 2014.
  - 407 people died from chronic liver disease between 2012 and 2014.
  - 4,900 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 14,780 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

## ii. The Mid Mersey Alliance LDS

- Alcohol misuse across the Mid Mersey Alliance LDS costs around **£271 million** each year. Of these costs:
  - **£61 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£24 million in social services cost** (Children's and adults social service provision)
  - **£74 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
  - **£116 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the Mid Mersey Alliance LDS, 26% of the adult population (168,261 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
  - All 4 CCGs have significantly higher rates of alcohol specific admissions
  - All 4 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
  - All 4 CCGs have significantly higher rates of alcohol related admissions (broad definition).
  - 3 out of 4 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the Mid Mersey Alliance LDS:
  - 334 people died from an alcohol-specific condition between 2012 and 2014.
  - 340 people died from chronic liver disease between 2012 and 2014.
  - 3,890 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 10,775 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

### iii. North Mersey LDS

- Alcohol misuse across the North Mersey LDS costs around **£271 million** each year. Of these costs:
  - **£72 million are direct costs to the NHS** (Hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
  - **£26 million in social services cost** (Children's and adults social service provision)
  - **£103 million are related to crime and licensing** (Alcohol specific and alcohol related crimes, costs of licensing)
  - **£129 million to the workplace** (Absenteeism, presenteeism, unemployment, premature mortality)
- Drinking at levels that can harm health is common. In the North Mersey LDS, 25.9% of the adult population (185,169 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.
- When compared to England:
  - All 3 CCGs have significantly higher rates of alcohol specific admissions
  - 2 out of 3 CCGs have significantly higher rates of alcohol related admissions (narrow definition) and
  - All 3 CCGs have significantly higher rates of alcohol related admissions (broad definition).
  - All 3 CCGs have significantly higher rates of alcohol specific mortality
- In terms of numbers affected across the North Mersey LDS:
  - 438 people died from an alcohol-specific condition between 2012 and 2014.
  - 403 people died from chronic liver disease between 2012 and 2014.
  - 5,055 people were admitted to hospital due to an alcohol-specific condition in 2014/15.
  - 12,309 people were admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code in 2014/15.

### e) Alcohol misuse is a major cause of health inequalities

Alcohol misuse is a major cause of health inequalities across the region with the most deprived members of our communities suffering from the higher levels of alcohol-related harm than more affluent areas. Across Cheshire and Merseyside lower socioeconomic status (SES) is associated with higher mortality for alcohol related causes.

Research has suggested that alcohol can be seen as a contributing factor for almost 50% of the indicators within the Public Health Outcomes Framework for England. Addressing alcohol-related harm would therefore be a key route to improving public health and reducing general health inequalities.

**f) *An opportunity to act at a system level and at scale to reduce alcohol-related harm***

There is enormous scope to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm delivered through alcohol strategies within local government. In addition there is the Reducing Alcohol Harm through Licensing group which will review evidence and lead action at scale around issues such as licensing and availability, campaigns, and price across Cheshire and Merseyside.

This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

## 2. Assumptions & Constraints

**Assumptions and constraints will describe** the context, given the continuing work to redefine and optimise pathways and services that each programme will need to support and underpin. This will include a series of assumptions and constraints about how the pathways or services will operate in the future.

**Your Plan** should then describe which how your programme relates to, and contributes towards, the changes required in these pathways or services and how you will use them as parameters for your design work.

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### 1. **Assumptions** relate to:

- a. **The cross-sector systems approach**
- b. the **relationship** between **outputs** and short, medium and longer term **outcomes** and **impacts**
- c. **Economic modelling and the return on investment** of interventions

#### a. **Cross – sector systems approach**

- Underpinning the alcohol harm reduction programme is a key assumption that the best way to improve outcomes for available resources is to take a cross-sector system approach to tackling alcohol-related harm with networks of partners delivering pathways of care that cover prevention, early identification and treatment.
- It is assumed that a Cheshire and Merseyside Alcohol Programme Board will be established to provide cross-sector system leadership across the sub-region, facilitating true integrated working and realisation of how interdependencies can yield improved outcomes despite challenging constraints on resources
- Successfully addressing alcohol misuse (outcomes, patient experience, and efficiency/productivity) will require an explicit system-wide commitment and change is required at scale.
- Service provision, particularly relating to public health and prevention will be significantly impacted by funding allocations and commissioning decisions taken by local authorities and NHS England.

#### b. The **relationship** between **outputs** and short, medium and longer term **outcomes** and **impacts**.

- Initial modelling has been undertaken to identify the relationship between outputs and short, medium and longer term outcomes and impacts. A key next step following the establishment of a system steering group will be the collaborative development of a logic model to identify short, medium and long-term outcomes linked to the key interventions outlined within this work programme.
- Evidence of impact on reducing alcohol-related harm comes from outside of Cheshire and Merseyside there is an assumption being made that impacts of these programmes will be replicable within Cheshire and Merseyside.
- There is an assumption that the proposed interventions will meet a real gap and need that isn't being met. For example related to the proposed Alcohol identification and brief advice (IBA). An IBA programme where there is genuinely no IBA currently

would have a given effect, however healthcare workers may currently provide alcohol advice but this is not identified as IBA.

- There is considerable synergy and overlap between the proposed interventions therefore there may be an overestimation of impact across the programmes.

### c. Economic modelling and the Return on Investment of interventions

- The evidence base for the financial impact of the proposed interventions is mainly based upon evaluations conducted elsewhere. An assumption has been made that impacts of these programmes will be replicable within Cheshire and Merseyside.
- The costs-benefit and return on investment of the proposed interventions has been modelled using best assumptions of costs and impacts available. Full details of assumptions made related to costs are included under costs within **Section 7 Facilities and Estates**.
- These modelled costs and benefits are only indicative based on best evidence. A more thorough exercise is required to understand what level of alcohol activity happens already across Cheshire and Merseyside as there is a lot of good practice already and a real awareness of the need to tackle alcohol as a driver of healthcare costs and costs to the whole economy.
- The CCG and LDS boundaries may not be completely coterminous. For the purposes of this analysis we have assumed that the Knowsley CCG population is in the Mid Mersey Alliance.
- In general we have taken a healthcare perspective to cost savings, but the cost savings could be much greater when criminal justice, private costs, and work productivity are factored in. Most evidence suggests that criminal justice cost savings may be greater than healthcare cost savings for interventions to reduce harmful drinking or support dependent drinkers. For instance, the Cardiff information sharing model produced estimated criminal justice savings of £5.4million over 5 years.
- Many of the healthcare cost savings are PbR reference cost type savings which would fall to the commissioner if they have a PbR contract. The reality is more complex as hospitals have fixed and variable costs and if one person is not in a hospital bed, very often another patient will take their place. But in the long run, cost savings from a reduction in alcohol related admissions should be realised.
- Bed days saved have been calculated based upon an average length of stay of 4 days.
- We are assuming that additional investment in alcohol care teams will produce the same kind of cost savings as seen in Bolton hospital, which saw a benefit cost ratio of £3.85 for every £1 spent. However we know that there has already been an investment in many areas of Cheshire and Merseyside; for instance the Royal Liverpool has been given as an example nationally of an alcohol care team. However there has also been audits that suggest many alcohol care teams do not include all of the crucial elements like a dedicated consultant lead and multidisciplinary team.
- We are assuming that a multi-agency approach to alcohol will produce similar results to those seen in the Nottinghamshire alcohol related long term conditions team pilot, which produced cost savings of £371,000 from an estimated programme cost of £200,000. However there is some uncertainty around whether these costs are accurate.
- We are assuming that alcohol Identification and Brief Advice (IBA) will produce an average £24 a year healthcare cost saving in individuals having an IBA over the next five years. This came from a presentation from Public Health England and is most likely a



conservative estimate. It is in line with other estimates from the NSMC social marketing tool and the National Institute for Health and Care Excellence (NICE) Return on Investment tool. For hospital admissions we are assuming that for every 171 individuals having an IBA, one hospital admission will be averted, which is from the NSMC Alcohol Behaviour Change Value for Money tool.

- In general, estimates of the cost savings from IBA vary hugely so a piece of work could be done locally to try to estimate more accurately the impact of IBA, for example by looking at the costs of alcohol admissions in different alcohol risk groups.
- We are assuming that investment in collection and sharing of intelligence in order to reduce alcohol-related violence will produce the type of healthcare cost benefits seen in the Cardiff model of information sharing; this produced an average healthcare cost benefit ratio of £14.80 for every £1 spent in the first five years.
- Several of the programmes we are proposing may have overlapping or similar objectives, for instance in identifying high risk drinkers, reducing unnecessary hospital admissions, and promoting intensive management of dependent drinkers. So some of the benefits from these discrete programmes may be double counted. Programmes may have a competitive effect (where they are competing for the same outcomes) or a synergistic effect (where the outcomes are actually greater than if the programmes were delivered alone).

## 2. **Constraints** relate to:

- a. Current lack of a **System Leadership Approach**
- b. **Finance**
- c. the **evidence base**

- a. **System Leadership Approach:** A system leadership approach needs to be established for the alcohol work stream. This may impact upon when interventions can be delivered creating a longer lag until benefits will be realised. Creating the governance to work collaboratively will be challenging, particularly with fragmented commissioning arrangements at local and regional levels.
- b. **Finance:** Austerity and financial pressure across all sectors limits resources and opportunities. The proposed interventions will deliver financial savings over the course of the 5 years. However some investment may be required to “invest to save”. Without additional financial resource to pump-prime the alcohol programme, the ability of the interventions set out in the action plan to close the three ‘gaps’ will be greatly lessened.
- c. **Evidence base:** The evidence base for the proposed alcohol interventions is generally strong however gaps and uncertainties remain in the evidence base which could benefit from further research.

## 3. **Risks**

Risk management (RM) will form an integral part of the programme planning and the review cycle and is firmly embedded within the governance arrangements. The simple, but proven approach to RM involves the identification of key risks in each of the workstreams through the application of our RM policy. A risk management policy is in place that will provide a standardised approach to the identification, assessment, recording and reporting of risks. An integrated risk log will be developed as part of robust programme management

approach and will analyse the causes of a risk and identify current controls to manage the outcome to mitigate the likelihood and impact. The key controllable risks are outlined below:-

- Drinking at levels that can harm health is currently common. In Cheshire and Merseyside, 26.5% of the adult population (623,477 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health. Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. In addition to its impacts upon health alcohol is associated with significant social harms such as violence, domestic abuse and road traffic accidents. We also know that it is the poorer members of our communities who suffer the highest levels of alcohol-related harm. If we do not act now to reduce alcohol-related harm then increases in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.
- **Public Engagement.** The costs for implementing a programme at scale are low but there is the risk that the public may not engage with the programme. This will be mitigated by ensuring good communications, engaging charities, public/patient groups/ community initiatives as part of a systems approach to implementation.
- There is a risk that there is insufficient **system capacity** to deliver the programme at scale (staff, IT etc).
- **Professional Engagement:** There is a risk that the system (NHS Secondary Care, CCGs and primary care clinicians) may fail to engage and implement the programme. Mitigated by Substantial engagement with clinicians including PHE/Strategic Clinical Network, and clinical champions.

### 3. Model of Care and/or Service Model

**The profile for the pathway/service line being described** should contain information regarding, but not limited to, the following;

- *The model of care, including how the three dimensions of quality will be delivered:*
  - *Patient Safety*
  - *Patient Experience*
  - *Clinical Effectiveness*
- *The Service Model, including:*
  - *Sub specialities*
  - *Location(s) of pathway/service delivery*
  - *Attributes of pathway/service delivery (those that merit highlighting)*

**Your Plan** should then describe which aspects of the model of care and service model you will use the change programme as an opportunity to further enhance.

#### **Taking a system leadership approach to reducing alcohol-related harm across Cheshire and Merseyside**

As outlined there is enormous scope within Cheshire and Merseyside to prevent alcohol-related harm in order to improve health and social outcomes and reduce demand on the health and wider economy.

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan.

This plan outlines how the NHS will work closely with local government and other local partners to build on existing local efforts and strengthen and implement interventions to reduce alcohol-related harm and close the local health and wellbeing gap.

In order to reduce alcohol-related harm within Cheshire and Merseyside we propose the following:

- 1) Enhanced support for high impact drinkers in hospital and community settings
- 2) Large scale delivery of targeted brief advice
- 3) Effective population-level actions are in place to reduce alcohol-related harms

Reducing alcohol-related harm is everybody's business. The programme plan recognises that there is considerable amount of activity going on outside the NHS to reduce alcohol-related harm. This alcohol programme plan completes the jig saw by focusing upon areas within which the NHS (with support and in partnership) can play a key role to reduce alcohol-related harm.

## **PRIORITY 1) ENHANCED SUPPORT FOR HIGH IMPACT DRINKERS**

- Alcohol currently places a high burden of harm on emergency services and hospitals across Cheshire and Merseyside however a significant proportion of this harm is avoidable.
- A small number of alcohol dependent clients are resistant to change placing a significant burden on public services through frequent hospital attendances, admissions and repeat offending. It has been estimated that 75% or more of dependent drinkers are not in treatment at any one time.
- In other areas alternative approaches and care pathways have been established for change resistant drinkers which have been proven to improve outcomes and save money and resources (**See Case study 1**).
- Effective hospital based alcohol care teams have been shown to reduce hospital admissions and readmissions. We know that there has already been an investment in many areas of Cheshire and Merseyside; for instance the Royal Liverpool has been given as an example nationally of an alcohol care team. In addition a recent PHE survey found that the majority of hospitals across Cheshire and Merseyside have an alcohol care team, however that the majority of those services are alcohol liaison nurse services. These services may benefit from further enhancement to meet national standards for best practice alcohol care teams. Evidence suggests that to be most effective such services should be multi-disciplinary, led by a consultant and supported by an alcohol assertive outreach service to manage the most frequent attendees (**See case Study 2**).
- There is beneficial overlap with priority 2 and 3 as a key role of hospital based alcohol care teams is the delivery of alcohol identification and brief advice (IBA) within the hospital setting (through direct delivery and education and training of wider hospital staff) to those identified as drinking at increasing or higher risk levels.

### **Aim of this priority:**

To reduce the harm to individuals whose alcohol use impacts most heavily on services.

### **Actions:**

In order to achieve this aim we will:

- D. Develop **multi-agency approaches to support change resistant drinkers**
- E. Ensure the **provision of best practice multidisciplinary alcohol care teams in all acute hospitals.**
- F. Review alcohol treatment pathways and **commission outreach teams in hospitals or the community** that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.

### ***Case Study 1: Supporting high impact service users - The Blue Light project***

The *Blue Light Project* is Alcohol Concern's national initiative to develop alternative approaches and care pathways for change resistant drinkers who place a huge burden on public services. The project has shown that there are positive strategies that can be used with this group. Moreover, the approach has demonstrated a **reduction in demand on emergency and acute services** leading to significant **returns on investment**.

The Blue light project has been developed in partnership with Public Health England and approximately 50 local authorities across the country.

The two key elements of the local transformation work are:

- **Training of specialist and non-alcohol specialist staff in the *Blue Light* approach.** This will ensure that staff across the health, social care, housing and criminal justice services, are identifying these clients and impacting on their behaviour.
- **Development of multi-agency operational group** to ensure a joint identification and ownership of the highest impact clients and ensuring a consistent and persistent focus on these individuals.

#### **Impacts observed in other areas include:**

- ✓ Increased engagement and successful treatment with community alcohol treatment services
- ✓ Reduced demand on emergency and acute services through:
  - Reductions in ambulance call outs
  - Fewer emergency department attendances
  - Fewer unplanned admissions

#### ***Wider positive impacts:***

- ✓ Improved multi-agency working
- ✓ Reduction in police incidents and criminal activity
- ✓ Identification and management of safeguarding issues
- ✓ Improved housing and employment status.

#### ***References***

Alcohol Concern. Working with Change Resistant drinkers: The project manual.

### ***Case Study 2: Alcohol Care Teams: Reducing acute hospital admissions and improving quality of care***

Detailed evidence-based recommendations for models of multidisciplinary alcohol care in acute hospitals have been drafted by the British Society of Gastroenterology, the Alcohol Health Alliance UK, and the British Association for Study of the Liver, along with those of the Quality, Innovation, Productivity, and Prevention (QIPP) case study, and the Health First: an evidence based alcohol strategy for the UK.

#### **Acute hospital model for an alcohol care team**

- A consultant-led, multidisciplinary, patient-centred alcohol care team to be integrated across primary and secondary care
- 7 day alcohol specialist nurse service
- Coordinated policies for the emergency department and acute medical units
- Rapid assessment, interface, and discharge liaison psychiatry service
- An alcohol assertive outreach team for frequent attenders to hospital
- Formal links with local authority, clinical commissioning groups, public health, and other stakeholders

#### **Impact:**

##### **The Royal Bolton Hospital**

The Royal Bolton Hospital collaborative care for alcohol-related liver disease and harm is a multidisciplinary team consisting consultant gastroenterologists, a liaison psychiatrist, a psychiatric alcohol liaison nurse, a liver nurse practitioner and a dedicated social worker.

The introduction of the 7 day alcohol liaison service cost £165,000 annually, saving 2000 bed days (current tariff is £318 per day) and £636,000 (£471,000 net) annually, and liberating 4-6 hospital beds.

##### **Alcohol assertive outreach service in Salford**

The alcohol assertive outreach service team works with a cohort of the top 30 patients (frequent attenders) with the highest levels of alcohol-related admissions over a 6-month period. Each 6 months, this cohort is refreshed. The team also works proactively with any patient, who has had 2 alcohol-related admissions within a short period of time, the so-called 'fast risers'.

Work with the first top 30 cohort resulted in a 59% reduction in Emergency Department attendances in the 3-month period post-intervention, when compared with the 3-month period before intervention (average monthly attendances were reduced from 120 to 49). There was also a 66% reduction in average monthly hospital admissions (50 to 17).

#### **References**

- NICE. Quality and Productivity: Proven Case Study. Alcohol care teams: reducing acute hospital admissions and improving quality of care.
- Public Health England. Alcohol care in England's hospitals: An opportunity not to be wasted.

## **PRIORITY 2) LARGE SCALED DELIVERY OF TARGETED BRIEF ADVICE**

- We recognise that much of the harm from alcohol use can be attributed to the drinking habits of non-dependent drinkers.
- Through reducing alcohol consumption among increasing and higher risk drinkers we can have a significant impact upon reducing future alcohol-related harm and hospital admissions due to alcohol-related conditions.
- Alcohol IBA is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. The evidence base for the effectiveness of IBA is strong.
- Screening undertaken as part of alcohol IBA may identify dependant drinkers who can then be referred onto specialist community alcohol treatment services.
- There is beneficial overlap with priority 1 as a key role of hospital based alcohol care teams is the delivery of alcohol identification and brief advice (IBA) within the hospital setting (through direct delivery and education and training of wider hospital staff).
- There is also beneficial overlap with priority 3 as once identified individuals can be offered alcohol identification and brief advice (IBA) by appropriately trained staff within hospital and ambulance services and referred onto alcohol care teams in the acute hospital setting or community alcohol treatment services.
- Although this priority is focussed upon upskilling staff to deliver IBA. There is also the potential to use digital technology to deliver self-directed IBA across Cheshire and Merseyside linked to delivery of a proposed Cheshire and Merseyside social norms campaign aimed at reducing alcohol consumption (*Drink less, Enjoy More campaign*).

### **Aim:**

To reduce population level alcohol consumption and associated alcohol-related harm through implementation of system-wide targeted advice and care.

### **Actions:**

In order to achieve this aim we will:

- C. Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and provide brief advice and refer to local specialist services as required.
- D. Ensure screening and advice by non-NHS partners as part of the delivery of ***Making Every Contact Count (MECC) interventions***. This will include evidence-based alcohol IBA as well brief interventions focusing on High Blood pressure (BP) (including BP checks), smoking cessation, diet and physical activity.

N.B. The **Making Every Contact Count (MECC) intervention** is also included within the High Blood Pressure Programme Plan.

**Example of overlap between alcohol and high blood pressure work streams:**

A patient attends the GP practice for a blood pressure (BP) check. The healthcare assistant takes the BP and it is found to be very high so the patient is asked about any lifestyle factors that may be affecting it and an alcohol risk assessment is undertaken using the AUDIT-C screening tool. The Alcohol IBA pathway is commenced when the patient is found to be AUDIT C positive. The healthcare assistant feels confident to provide appropriate advice and liaise directly with other services in the pathway because she knows who they are, where they are located and whether they are relevant for this particular patient.

**Case Study 3: Alcohol Identification and brief advice (IBA)**

Alcohol IBA is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. It is a preventative approach aimed at identifying and providing brief advice to increasing and higher-risk drinkers. IBA is both effective and cost effective in reducing the risks associated with drinking.

***The evidence for IBA is strong***

The World Health Organisation and the Department of Health have both acknowledged over 50 peer reviewed, academic studies that demonstrate IBA is both effective and cost effective in reducing the risks associated with drinking.

***Impact:***

- 1 in 8 recipients of IBA reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years. This compares with 1 in 20 smokers who benefit from stop smoking advice.
- Identification and Brief Advice (IBA) can reduce weekly drinking by between 13% and 34%, resulting in 2.9 – 8.7 fewer drinks per week. This will reduce relative risk of alcohol-related conditions by 14%, and absolute risk of lifetime alcohol-related death by 20%.

**References**

The Health Innovation Network. Alcohol Identification and Brief Advice (IBA) toolkit. [http://www.hin-southlondon.org/system/resources/resources/000/000/223/original/HIN\\_AIBA\\_Toolkit\\_v15\\_FINAL.pdf](http://www.hin-southlondon.org/system/resources/resources/000/000/223/original/HIN_AIBA_Toolkit_v15_FINAL.pdf)



### **PRIORITY 3) EFFECTIVE POPULATION-LEVEL ACTIONS ARE IN PLACE TO REDUCE ALCOHOL-RELATED HARM.**

#### **Highlight effectiveness of population based approaches**

- Alcohol-related violence places a significant burden upon emergency departments, emergency services and the criminal justice system.
- It is estimated that just over half of total violent incidents involving adults were alcohol related.
- Emergency Departments (EDs) can contribute distinctively and effectively to alcohol-harm reduction and violence prevention by working with Crime and Disorder Partnerships and sharing simple anonymised data.
- Ambulance services can also identify alcohol-related harm and violence.
- This information can then be used to targeting interventions to prevent violence and reduce alcohol-related harm through targeted interventions and the use of intelligence in the license review process.
- There is beneficial overlap with priority 1 and 2 as once identified individuals can be offered alcohol identification and brief advice (IBA) by appropriately trained staff within hospital and ambulance services and referred onto alcohol care teams in the acute hospital setting or community alcohol treatment services.
- This priority is strongly linked to activity going on outside the NHS to reduce alcohol-related harm delivered through local government licensing work.

#### **Aim:**

To prevent alcohol-related violence and to reduce alcohol-related harm.

#### **Actions:**

In order to achieve this aim we will:

- D. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards (As outlined by College of Emergency Medicine (CEM) Guidelines and the Standard on Information Sharing to Tackle Violence).**
- E. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners**
- F. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include:**
  - i. Targeting interventions to prevent violence and reduce alcohol-related harm**
  - ii. Targeting police enforcement in hotspot areas**
  - iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement**

#### **Case Study 4: Sharing of data to reduce alcohol-related violence**

Addenbrooke's Hospital has been collecting and sharing data since 2007. Their work in this area was prompted by A&E consultant Adrian Boyle seeing the evidence that had emerged from the work done in Cardiff and realising the potential to prevent violent assaults in Cambridge. All data collection takes place at the point of patient registration. Receptionists collect three core data items: a free text description of the location of the assault, the date and time of assault and what weapon was used.

#### **Impact:**

Addenbrooke's has seen a 20% reduction in the number of assaults requiring emergency department care and a 35% reduction in the violent crimes with injury reported to the police. The data collected by the Emergency Department was instrumental in supporting Cambridge City Council uphold a case against a licensing appeal that had been made.

*"This activity has been one of the most effective things we have done and we feel really good about having prevented over 200 assault victims a year needing hospital treatment."*

**Adrian Boyle, Consultant in Emergency Medicine**

Further case studies available at: <http://www.alcohollearningcentre.org.uk/Topics/Latest/ED-Datasharing-Case-Studies/>

## 4. Performance

**Performance should describe** the current, as well as trend, levels of demand for the pathway/service being defined; this information should be contrasted with the current, as well as trend, capacity in the pathway/service. This should lead to an explanation of the current, as well as trend, level of activity.

**Your Plan** should then describe which dimensions of the performance you will use the change programme to further transform and any opportunities for business development that you use the programme to exploit.

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. This systems leadership approach will support and add value to the implementation of local strategies. This group would have oversight and be accountable for implementation of the FYFV action plan. A key initial action following the establishment of the system steering group will be the collaborative development of a logic model to identify short, medium and long-term outcomes linked to the key interventions outlined within this work programme and the development of a performance dashboard.

We propose the following high level Key Performance Indicators (KPIs) to monitor the impact of the proposed interventions:

**KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE)**

**KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)**

**KPI3: - Identification and Brief Advice (IBA) (Local indicator needs to be developed)**

- D. Alcohol screening:** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
- E. Alcohol brief advice:** Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice
- F. Alcohol referral:** Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team

*Proposed indicators based upon NHS providers meet Preventing ill health by risky behaviours CQUIN (<https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-a-cquin.pdf>)*

**KPI4: Alcohol-related violence (Local indicator needs to be developed)**

Current performance against KPIs is as follows:

KPI	Description	Cheshire and Wirral LDS	Mid Mersey Alliance LDS	North Mersey LDS	Cheshire and Merseyside
<b>KPI1: Emergency hospital admissions rates for alcohol specific admissions</b>	Number of CCGs with higher than national hospital admissions rates for alcohol specific admissions	2 out of 5 (2012-2014)	4 out of 4 (2012-2014)	3 out of 3 (2012-2014)	9 out of 12 (2012-2014)
	Number of hospital admissions rates for alcohol specific admissions	4,900 (2014/15)	3,890 (2014/15)	5,055 (2014/15)	13,845 (2014/15)
<b>KPI2: Mortality from alcohol specific conditions</b>	Number of CCGs with higher than national mortality from alcohol specific conditions	1 out of 5 (2012-2014)	3 out of 4 (2012-2014)	3 out of 3 (2012-2014)	7 out of 12 (2012-2014)
	Number of deaths from alcohol specific conditions	440 (2014/15)	334 (2014/15)	438 (2014/15)	1,212 (2014/15)
<b>KPI3: - IBA</b>	A. Alcohol screening	<i>Currently unknown: Local indicator needs to be developed</i>			
	B. Alcohol brief advice	<i>Currently unknown: Local indicator needs to be developed</i>			
	C. Alcohol referral	<i>Currently unknown: Local indicator needs to be developed</i>			
<b>KPI4: Alcohol-related violence</b>	<i>To be developed</i>	<i>Currently unknown: Local indicator needs to be developed</i>			

Targets for progress and timescales for each KPI will be developed by the system steering group.

## 5. Staffing

***This section should describe all those staff groups that make a substantive contribution to the delivery of the pathway/service being described. The current numbers, as well as the trends, should be graphically demonstrated for the following groups:***

- *Social Care*
- *Medical*
- *Nursing*
- *Allied Health Professionals (AHP)*
- *Managerial*
- *Administrative and Clerical*

*This section should also address the current position and trends relating to:*

- *Sickness and absence*
- *Annual appraisals*
- *Recruitments and retention*
- *Availability*
- *Productivity*
- *Any on-going actions in response to staff surveys*

***Your Plan*** should then describe which aspects of the pathway/service staffing you will use the change programme as an opportunity to further develop.

### ***Key local stakeholders:***

- 12 CCGs
- 9 Local Authorities
- Acute Trusts
- Community services
- Primary Care
- Public Health England NW
- NHS E C&M
- Cheshire and Merseyside Public Health Collaborative (Champs)
- Voluntary Sector organisations
- C&M Fire and Rescue Services
- Merseyside & Cheshire Police Forces

The proposal includes a specific programme manager post within the System Leadership team to facilitate and manage engagement and co-operation between different stakeholders.

Due to the nature of the cross-sector approach, the staffing groups that contribute to the delivery of the alcohol priorities are many. Key staff groups by priority include:

### **Priority 1: Enhanced support for high impact drinkers in hospital and community settings**

- Specifically commissioned teams in secondary & acute care and community outreach
- Staff in local authority commissioned specialist alcohol treatment services
- Adult Social Care
- Adult mental health services

- Housing trusts
- Police
- Ambulance services
- Community and voluntary sector

**Priority 2: Large scale delivery of targeted brief advice**

- Community pharmacy staff, including Healthy Living Pharmacy leads and champions
- Primary care teams including GPs, Practice nurses, Health care workers, receptionists
- Secondary care, all staff with an opportunity/ training to do a brief intervention as part of the Making every contact count (MECC) programme
- Staff in any other applicable MECC provider

**Priority 3: Effective population-level actions are in place to reduce alcohol-related harms**

- Community safety partnerships, Police, Ambulance Services
- Acute care department reception staff, managers, doctors and consultants
- Acute care trust IT staff and analysts

## 6. Information Management & Technology

***This section should describe*** the current, as well as planned use of IM&T as an enabler to the aims of the programme. The analysis should include current experience with IM&T including issues that cause problems. The levels of capability to use the IT systems should feature along with levels of support and training required.

***Your Plan*** should then describe what new systems and other IM&T solutions form part of the wider improvement aspirations for the pathway/service and how they will be realised.

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IM&T is a key enabler to the aims of the programme and the measurement of impact. Population health management systems, which join up datasets across primary, secondary and community care, that are currently being delivered within Cheshire and Merseyside e.g. The Wirral Care Record and Population Health Registries will support the identification and management of individuals suffering from alcohol-related harm. Such systems can also be used to evaluate the impact of the proposed interventions.

Both priorities 1 and 2 require basic levels of IT use and both can be achieved within existing IT provision with minor changes to data collection.

In order to monitor IBA delivery across Cheshire and Merseyside and the three Local Delivery Systems (LDS) data will need to be collected and analysed related to:

- A. Alcohol screening: Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems
- B. Alcohol brief advice: Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice
- C. Alcohol referral: Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team

These proposed indicators are based upon NHS providers meet Preventing ill health by risky behaviours CQUIN (Further details available here: <https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-a-cquin.pdf>).

It may be that areas with developed population care records can pilot the method of capturing of IBA offered across the health and social care system and share learning with other areas.

There is also potential to use digital technology to deliver IBA across Cheshire and Merseyside linked to delivery of a Cheshire and Merseyside social norms campaign aimed at reducing alcohol consumption (*Drink less, Enjoy More campaign*).

Priority 3 relies on collection of specific data (e.g. violence location, time, date, weapon and assailants, alcohol consumption). Following previous work on the C&M wide Trauma and Injury Intelligence Group (TIIG) most, if not all, EDs within the area collect some of this data already or can quickly reinstate it. This work would be an opportunity to standardise the data collected and ensure it complies with best practice models e.g. The Cardiff Model.

Relevant data collection, IT support and links with crime reduction partnerships can be achieved at no extra cost to local EDs and Crime & Disorder Reduction Partnerships (CDRPs) are funded to facilitate data sharing.

The model requires Hospital Trust IT capacity to anonymise and share ED data. Based upon learning from implementation in other areas the process flows as follows:

- Step One:** 24 hour electronic data collection by ED clerical staff when patients first attend.
- Step Two:** Monthly anonymisation and sharing of data by Hospital Trust IT staff with Crime & Disorder Reduction Partnerships (CDRP) analyst.
- Step Three:** Monthly combination of police and ED data by CDRP analyst.
- Step Four:** Summary of violence times, locations and weapons by CDRP analyst.
- Step Five:** Continuous implementation and updating of prevention action plan by CDRP violence task group.
- Step Six:** Continuous tracking of violence trends – overall trends and trends in violence hotspots.



## 7. Facilities & Estates

***This section should describe the future plans for pathway/service within a given environment(s). There will be a description of the facilities that will be required by, and made available to, the pathway/service as well as a comprehensive understanding of the space to be occupied. The section will also include details of equipment requirements that may be new or significant enhancements.***

***Your Plan should then describe how the pathway/service will deliver its vision for the future within the new environment.***

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All plans are designed to be realised within existing facilities and estates belonging to key partners in community pharmacies, primary and secondary care.

- System Enablers:
  - Systems Leadership
  - Communications and Engagement
  - Evaluation
  - Non labour and Overheads
- Provision of MDT Alcohol Care Teams in Acute Providers and outreach teams
- Multi-agency approach to support change resistant drinkers
- Identification and Brief Advice (IBA)
- Collection and sharing of intelligence in order to reduce alcohol-related violence

## 8. Interdependencies

***This section should describe the current interdependencies that the pathway/service has with other teams and services. This includes both those products and services you require from others to operate successfully as well as those products and services that you provide which are essential to the operations of others. Any current issues should be highlighted along with the plans for the plans to resolve them.***

***Your Plan should then describe how those interdependencies will be assured through the programme of change. This could be by reference to programme participation as stakeholders; joining/monitoring a programme upon which you may have a key interdependency. Alternatively, you may simply choose to reference the specific programme plan that will be addressing that interdependency.***

In order to effectively reduce alcohol-related harm we propose establishing a system wide leadership approach through the development of a Cheshire and Merseyside cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol-related harm. A robust management approach that will be taken and through this governance structure, interdependencies between each programme and cross cutting themes and across the local delivery systems will be identified and the impact understood.

This will be achieved by the development of a performance dashboard that captures key outputs and outcomes from across the system enabling the importance of interdependencies to be demonstrated and embedded.

### Operational Level Interdependencies

Within this system, a wide range of interdependencies and partnership working will evolve between key stakeholders as the system leadership approach will be developed and implemented. This includes but is not limited to:

- Acute Trusts/ Secondary Care (which providers)
- Community services
- Primary Care
- NHS England (C&M)
- PHE (NW)
- Champs Public Health collaborative (PH teams from 9 local authorities and lead Commissioners/Alcohol Leads)
- Voluntary sector partners
- Cheshire and Merseyside Fire and Rescue
- 12 Clinical Commissioning Groups
- Academia
- Community Pharmacy
- Cheshire and Merseyside Police Force

## **Tactical and Strategic Interdependencies**

Taking action to reduce alcohol-related harm will have significant cross-sector benefits.

- **Benefits to other FYFV work streams:** Including but not limited to the Blood pressure priority, cancer, cardiovascular disease and mental health.
- **Benefits beyond the NHS:** across the criminal justice, social care and wider economy.

## 9. Benefits

***This section should describe the impact the programme will have on the following three ‘gaps’ which are at the heart of the 5YFV:***

- ***The health and wellbeing gap:*** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- ***The care and quality gap:*** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients’ changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- ***The funding and efficiency gap:*** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

***Your Plan should then describe which benefits will accrue against which ‘gap’ in terms of baseline, target, and planned trend of improvement to meet the benefit target in time. The objectives to support benefits realisation should be SMART objectives, that is: Specific, Measurable, Achievable, Realistic, Time bound.***

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The impact of this programme on the three ‘gaps’ are set out below.

### 1. Closing the Health and Wellbeing gap

Through this cross-sector system approach to reducing alcohol-related harm, LDSs across C&M will be ensuring patients receive the most appropriate interventions in the right places and at the right time, driving a cultural shift towards prevention and self-care.

On an **operational level**, the programme of work aims to prevent, identify and manage alcohol-related harm. The impact of this will be a reduction in emergency admissions due to alcohol and alcohol-related conditions and reduced demand on health and social care.

On a **tactical level within the C&M FYFV**, upstream approaches to address alcohol-related harm will also benefit other cross-cutting themes within the FYFV (e.g. cancer, CVD, High Blood Pressure, mental health).

On a **strategic level**, the longer term benefits of the prevention of future illness, both in terms of those related to alcohol, as well as those in other cross-cutting themes, is to strengthen the future sustainability of the wider C&M FYFV.

### 2. Closing the care and quality gap

Cheshire and Merseyside suffers from high levels of alcohol-related harm when compared to other regions. The proposed interventions to reduce alcohol-related harm will help close the care and quality gap. Closing this gap will lead to observed benefits in terms of fewer hospital admissions and saved bed days.

The proposed interventions to reduce alcohol-related harm will lead to clear benefits in terms of closing the care and quality gap across Cheshire and Merseyside by year 5. Benefits will be realised over the five years, not only at the five year point.

These benefits will be observed in terms of reductions in hospital admissions and reduced bed days saved.

Bed days saved have been calculated based upon an average length of stay of 4 days.

**Cheshire and Merseyside:** 4,081 fewer admissions due to alcohol  
Equating to 16,326 bed days saved.

**Wirral and Cheshire LDS:** 1723 fewer admissions due to alcohol  
Equating to 6894 bed days saved

**Mid Mersey Alliance LDS:** 1088 fewer admissions due to alcohol  
Equating to 4,352 bed days saved

**North Mersey LDS:** 1270 fewer admissions due to alcohol  
Equating to 5080 bed days saved

Further details of the benefits of the link between the proposed interventions and reduced admissions and bed days saved over the 5 year period is outlined within the Annex.

### **3. Closing the funding and efficiency gap**

Reducing alcohol-related harm will help close the funding and efficiency gap across Cheshire and Merseyside.

The costs and benefits of the proposed alcohol interventions have been modelled at a Cheshire and Merseyside and LDS level.

**The net financial benefit at after 5 years of implementing this programme has been estimated at:**

- **Cheshire and Merseyside:** £11,274,000
- **Cheshire and Wirral LDS:** £4,760,000
- **Mid Mersey Alliance LDS:** £3,005,000
- **North Mersey LDS:** £3,508,000

These are likely to be underestimations of the proposed financial benefits:

- We have taken a healthcare perspective to cost savings, but the cost savings could be much greater when criminal justice, private costs, and work productivity are factored in. Most evidence suggests that criminal justice cost savings may be greater than healthcare cost savings for interventions to reduce harmful drinking or support dependent drinkers. For instance, the Cardiff information sharing model produced estimated criminal justice savings of £5.4million over 5 years.

- No costs or benefits of the proposed MECC has been included within the cost-benefit analysis.

Assumptions related to the economic modelling undertaken is included within **Section 2: Assumptions and Constraints**.

A full breakdown of economic calculations and their release over the 5 year period is included within the Annex.

## 10. Proposed Action Plan

*The art of the Action Plan is to ensure that it is comprehensive, compelling and timely. The Action Plan should address all of the salient points highlighted in the other sections of the report; namely, all those points where **Your Plan** will act as a change programme to help close the three gaps. As such, and like the executive summary, it should therefore contain no information that does not already appear in the contents of the PID.*

*Otherwise, the content of the Action Plan should deliver milestones which address, but are not limited to, the following three ‘gaps’ (as described in the ‘Benefits’ Section above):*

- **The health and wellbeing gap:** *if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.*
- **The care and quality gap:** *unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients’ changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.*
- **The funding and efficiency gap:** *if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.*

*The 5YFV states that none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there. Changes to capacity and or activity in response to trends in demand*

*The Action Plan should also promote accountability by having a named individual for each task. Finally, the action planning must provide assurance as to how the change will be made to happen and that there is the capacity and capability in place to underpin delivery. All action plans should be governed by a Programme Board or similar entity.*

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An action plan is included on the next page.

Intervention	Aim			Objective	5YFV gap addressed			Lead/support	KPI	Target KPI change
					Financial	Health and Wellbeing	Care and Quality			
<b>1. FYFV demand reduction (Alcohol) steering group</b>	Overarching			<p>A. Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations with the responsibility for development and implementation of a system wide approach to reduce alcohol related harm. This systems leadership approach will support and add value to the implementation of local strategies. <b>This group would have oversight and be accountable for implementation of the FYFV action plan.</b></p> <p>B. <b>Business case</b>- work up a more detailed business case based on more accurate programme costings and including £ value for QALYs gained.</p> <p>C. Develop and continue to <b>risk register</b> (building on those set out in the PID document) and plans to mitigate risks, using a standardised approach to identification, assessment, recording and reporting of risks.</p> <p>D. Develop and implement a <b>Stakeholder engagement and communications</b> plan to mitigate the risk of failure of partners to engage</p> <p>E. Establish a data/outcomes working group responsible for evaluation framework/logic model that underpins the FYFV objectives.</p>	Y	Y	Y	Fiona Johnstone (Lead DPH for Alcohol). Champs Support Team programme lead (TBC) and wider system partners	Oversight of all 4 high level KPIs.	Collaborative development of a logic model to identify short, medium and long-term outcomes and target changes linked to the key interventions outlined within this work programme.
<b>PRIORITY 1. Enhanced Support for High Impact Drinkers</b>	Treatment			<p>A. Develop multi-agency approaches to support change resistant drinkers'</p> <p>B. Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals. A current scoping will be required in order to inform the future provision to optimal levels</p> <p>C. Review pathways and commission outreach teams in hospitals or the community that complement hospital based alcohol care teams by identifying and proactively engaging patients with repeated admissions as appropriate.</p>	Y	Y	Y	To be established via working group	KPI1: Emergency hospital admissions rates for alcohol specific admissions (National indicator: LAPE) KPI2: Mortality from alcohol specific conditions (National indicator: LAPE)	Year on year reductions over 5 years. N.B. cost-benefits (across whole programme) is based upon a 6% reduction in alcohol-specific admissions by year 5.
<b>PRIORITY 2. Large Scale delivery of targeted Brief Advice</b>	Detection			<p>A. <b>Identification and Brief Advice.</b> Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff trained to offer and provide brief advice and refer to local specialist services as required.</p> <p>B. Ensure screening and advice by non-NHS partners as part of the delivery of <b>Making Every Contact Count (MECC)</b> interventions to include evidence-based alcohol IBA as well brief interventions focusing on High BP (including BP checks), smoking cessation, diet and physical activity. <b>INTERDEPENDENT WITH BLOOD PRESSURE ACTION PLAN</b></p>	Y	Y	Y	To be established via working group	KPI3: - Identification and Brief Advice (IBA) ( <i>Local indicators need to be developed</i> ) A. Alcohol screening: Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems B. Alcohol brief advice: Percentage of unique patients who drink alcohol above lower-risk levels AND are offered brief advice C. Alcohol referral: Percentage of unique patients who are indicated as potentially alcohol dependent AND are offered referral to specialist services locally or in-house alcohol care team	Year on year increase over 5 years. NB cost-benefits (across IBA programme) is based upon undertaking IBA in primary care with 7.5% of adult population by year 5.
<b>PRIORITY 3. Effective population level actions</b>	Prevention			<p>i. Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards</p> <p>ii. Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners</p> <p>iii. Ensure local partners collaborate to ensure that the data collected is being used effectively and work together to consider where improvements can be made. This will include: i. Targeting interventions to prevent violence and reduce alcohol-related harm ii. Targeting police enforcement in hotspot areas iii. Use of intelligence in the license review process and targeting alcohol licencing enforcement</p>	Y	Y	Y	To be established via working group	KPI4: Alcohol-related violence ( <i>Local indicator needs to be developed</i> )	Year on year reductions over 5 years

## a) Annex

*The aim of an annex is to add greater details, visuals and examples for better understanding of the main document (e.g. Performance – you may wish to display a visual as an annex to refer to from the text within this section)*

## 2. Appendices

*An appendix is different from an annex in that it can be considered without the main text; it is a document in its own right that still makes sense if it stands alone. It cannot be added to the main text but still has importance as regards the original document.*

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Your content starts here.....